DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R-C 06/02/2015	
		15G202					
NAME OF PI	ROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE		
KNOX COUNTY ARC - BICKNELL 1				628 W 7TH ST			
				BICKNELL, IN 47512			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 000})} INITIAL COMMENTS		{W 0	00}			
	survey to the investig	ost-certification revisit (PCR) ation of Complaint eted on April 24, 2015.					
	Complaint #IN00171576-Corrected. Survey dates: June 1 and 2, 2015 Facility Number: 000732 Provider Number: 15G202 AIM Number: 100243240						
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.